DENTAL CARE

Patient Details

Patient name:

Patient address:

Patient phone number:

Patient email:

Possibility of Pregnancy? Yes / No

Referring Dentist Details

Dentist name:

Practice address:

Practice phone number:

Practice fax number:

Dentist email:

Information

Date:

Signature:

Payment: Patient to pay / Account to Referrer

Examination required:

- ☐ Digital OPG x-ray
- ☐ Cone Beam CT
- ☐ Digital cephalometric x-ray
- ☐ My patient will wear a stent

DENTAL CARE

Purpose:

Region of interest for CT Scan:

- ☐ Upper jaw
- ☐ Lower jaw
- ☐ Small volume (Please use diagram below)

Upper Right

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

8 7 6 5 4 3 2 1

Upper Left

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

1 2 3 4 5 6 7 8

Lower Right

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

8 7 6 5 4 3 2 1

Lower Left

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

1 2 3 4 5 6 7 8

Delivery Options:

- ☐ Email

Please specify the email:

Any additional information: